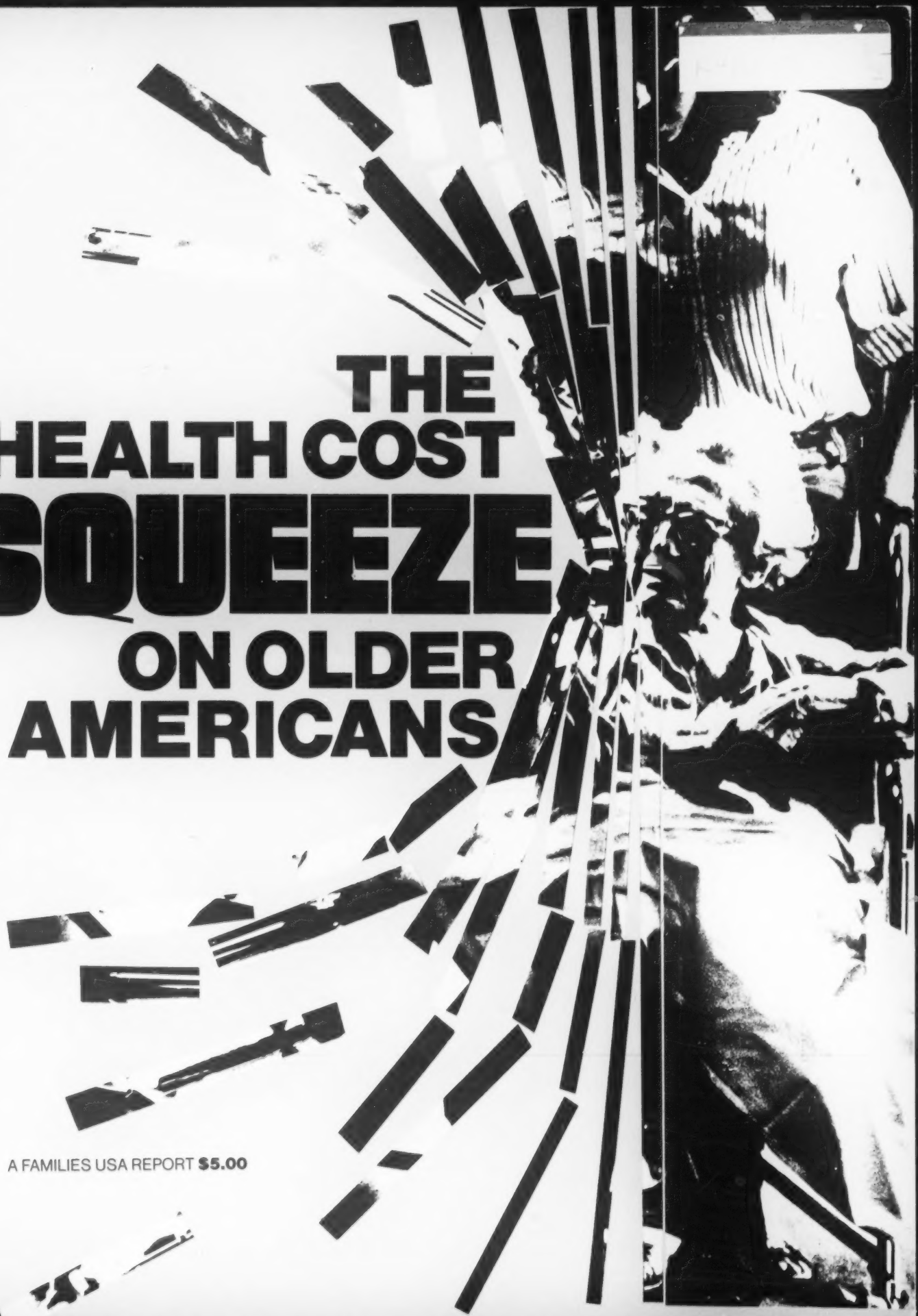
THE HEALTH COST SQUEEZE ON OLDER AMERICANS



A FAMILIES USA REPORT **$5.00**

The Health Cost Squeeze on Older Americans

A report by

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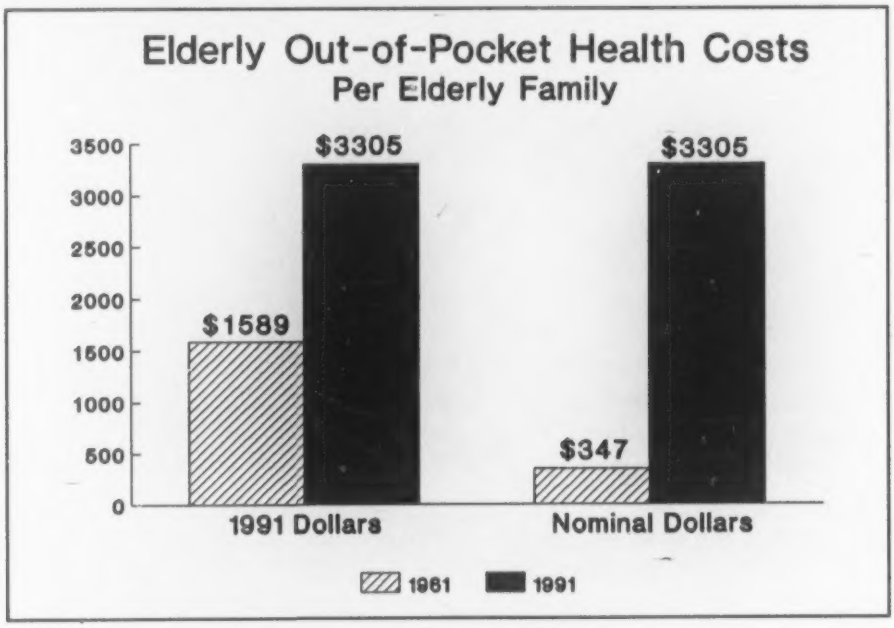
Introduction

Most people believe that the elderly are protected from the high cost of health care by the Medicare program. Unfortunately, an examination of elderly out-of-pocket expenses for health services indicates this is far from true. America's elderly families had out-of-pocket expenses of over $67 billion for health care in 1991. This amounts to more than a three fold increase over the roughly $17.5 billion ($3 billion in nominal dollars) spent out-of-pocket for health care in 1961 before Medicare began.*

For the majority of elderly families who live on a fixed income, it is increasingly difficult to absorb these expenses. Social Security checks do not increase in real terms; they increase at a rate that is roughly equal to increases in the cost of living. Many pensions do not increase at all, not even in nominal dollars. Thus, with health costs rising much faster than inflation, health costs are consuming ever larger portions of seniors' income.

The Medicare program was created in 1965 to provide America's elderly families with access to health services. Many of the elderly could not get private health insurance and therefore could not afford to get needed health care services. Over the intervening years, rapidly rising health costs have undermined Medicare's goal. Health care inflation has driven up the costs of both Medicare's uncovered services, most notably nursing home care and prescription drugs, and the amounts of the program's premiums, deductibles and co-payments for which elderly families must pay directly or for which they must purchase private insurance. Consequently, elderly families' out-of-pocket health costs have soared.



* Throughout this report, amounts of health spending are reported first in real 1991 dollars (adjusted for inflation) and the amounts in nominal dollars are reported in the parentheses.

Background

Elderly families pay out-of-pocket for a variety of different services. They pay Medicare premiums, $31.80 a month in 1992, which allow them to have insurance for physician costs under the program's Part B. Additionally, beneficiaries must pay the Part B deductible, $100 a year; co-payments of 20% for all physician charges above the deductible; physician costs that exceed the Medicare rate; a hospital (Part A) deductible of $652 for each hospitalization; substantial co-payments for hospitalizations in excess of 60 days; and substantial copayments for skilled nursing home care stays longer than 20 days.

Instead of paying these directly, approximately 70% of the elderly have private Medigap insurance policies, which covers much of the out-of-pocket costs related to Medicare covered services. Additionally, most elderly families bear the complete financial burden for any nursing home services they need beyond 20 days of skilled care. Finally, most elderly families must pay entirely out-of-pocket for pharmaceuticals, vision and dental care, and other medical necessities.

This report examines trends in elderly families' out-of-pocket costs based on data from the Consumer Expenditure Survey, conducted in 1961, 1972, 1984 and 1989. The 1989 data has been updated to estimate 1991 results. (See technical appendix for additional information.) Tables 1A and 1B illustrate the trends in out-of-pocket health expenses as expressed in component form. The tables used in this report express the information in both real and nominal dollars.

Key Findings

▸ In 1991, America's elderly spent more than twice as much money on health care costs (almost ten times in nominal dollars) than they did prior to the establishment of the Medicare program. In 1961 elderly out-of-pocket costs averaged $1,589 in inflation-adjusted dollars ($347 in nominal dollars) per elderly family. By 1991, out-of-pocket costs had reached $3,305 per elderly family. (See Tables 1A and 1B.)

▸ These increases have been so steep that elderly families' average health expenses consume 17.1% of after-tax income—up from 10.6% of income in 1961. This amount does not include taxes elderly families pay that support government health programs. (See Table 2)

▸ The single largest component of elderly out-of-pocket costs is nursing home care, which increased more than four-fold since 1961 above general inflation (19-fold in nominal dollars). Nursing home costs, which accounted for approximately one-sixth of elderly families' out-of-pocket health costs in 1961, now consume over one-third of elderly families' out-of-pocket health costs. (See Tables 1A and 1B.)

▸ Premiums, including both private health insurance and Medicare, have more than tripled since 1961 above general inflation (increased almost 15-fold in nominal dollars). Consuming only 19% of all out-of-pocket costs in 1961, premiums now take up close to 30%. (See Tables 1A and 1B.)

▸ The costs of private health insurance more than doubled since 1961 above general inflation (increased close to 10 times in nominal dollars), even though the nature of the elderly market's insurance needs changed considerably. In 1961 health insurance purchased by the elderly generally was for major medical coverage. Today the majority of insurance policies purchased by elderly families are Medigap plans that supplement Medicare coverage. (See Tables 1A and 1B.)

▸ The Medicare premium has grown considerably over the years. Spending for Medicare premiums per elderly family increased by 50% in real dollars since 1972 (close to five-fold in nominal dollars). (See Tables 1A and 1B.)

▸ Out-of-pocket costs for physician services have grown by 29% in real dollars since 1961 (a six-fold increase in nominal dollars). (See Tables 1A and 1B.)

▸ Other health care costs—including pharmaceuticals, dental services, eye care services, practitioners other than physicians (e.g., chiropractors), nursing services, therapeutic treatments, lab tests, X-rays, hearing aids, medical devices and supplies—have begun to show significant growth. This category grew by 41% in real dollars from 1961 to 1991 (and increased six-fold in nominal dollars). (See Tables 1A and 1B.)

▸ The level of out-of-pocket costs is especially burdensome for low- and moderate-income elderly families. Almost two out of every five elderly families in the lowest quintiles of income were spending in 1989 more than 20% of their after-tax income on health care. Only 4.3% of families with incomes in the highest quintile have such expenses. This amount does not include costs for nursing home services which, if included, would increase costs by roughly one-third in the aggregate. (See Table 3.)

Components of Health Costs Increases

Health care costs have been growing at rates that far outpace those of general inflation. In the 1980s alone, health care costs grew at an average rate of 10.6% while the general inflation rate averaged 4.7%. While the Medicare program guarantees all seniors basic health insurance, it has not been sufficient to protect seniors from the effects of health inflation. As Table 1A indicates, from 1961 to 1991 elderly families' out-of-pocket health expenditures doubled after taking into account general inflation (and increased nine and one-half times in nominal dollars).

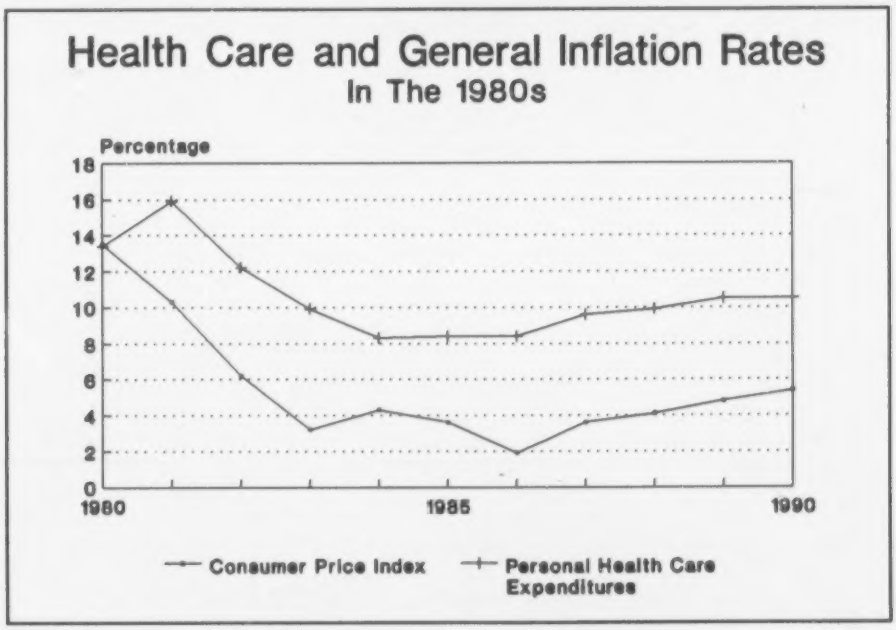


TABLE 1A

PER FAMILY OUT-OF-POCKET HEALTH EXPENDITURES BY THE ELDERLY[a]
(in 1991 dollars)

	1961	1972	1984	1989	1991[b]
Total	$1,589	$1,854	$2,698	$3,249	$3,305
Direct Out-of-Pocket	1,285	1,331	1,898	2,262	2,332
Hospital	228	175	83	91	90
Physician	316	184	424	392	408
Nursing Home[c]	287	582	972	1,173	1,194
Other	454	390	419	606	640
Insurance	304	523	800	987	973
Private Insurance	304	309	553	619	653
Medicare Premium	NA	214	247	368[d]	320

[a] Data for health expenditures, other than nursing home care, for 1961, 1972, 1984, and 1989 are based on the Consumer Expenditure Survey (CEX). Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model.

[b] Data for 1991 were estimated by Lewin/ICF.

[c] The CEX is a survey of non-institutionalized consumer units and does not capture nursing home expenditures. Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model. Adjustments were made to account for the change in the number of families when including nursing home residents.

[d] Medicare premiums in 1989 are unusually high because the $31.90 monthly Part B premiums contained an additional $4.00 per month for Part B services to cover the costs of benefits added by the 1988 Medicare Catastrophic Coverage Act (MCCA). MCCA was repealed, therefore the 1991 monthly premium of $29.90 was lower than in 1989.

NOTE: Expenditures are for consumer units headed by someone age 65 or older. A consumer unit comprises either: 1) all members of a particular household who are related by blood, marriage, adoption, or other legal arrangements; 2) a person living alone or sharing a household with others or living as a roomer in a private home or lodging house or in permanent living quarters in a hotel or motel, but who is financially independent; or 3) two or more persons living together who pool their income to make joint expenditure decisions.

TABLE 1B

PER FAMILY OUT-OF-POCKET HEALTH EXPENDITURES BY THE ELDERLY[a]
(nominal dollars)

	1961	1972	1984	1989	1991[b]
Total	$347	$566	$2,047	$2,941	$3,305
Direct Out-of-Pocket	281	406	1,440	2,048	2,332
Hospital	50	53	63	82	90
Physician	69	56	322	355	408
Nursing Home[c]	63	178	737	1,062	1,194
Other	99	119	318	549	640
Insurance	66	160	607	893	973
Private Insurance	66	94	420	560	653
Medicare Premium	NA	66	187	333[d]	320

[a] Data for health expenditures, other than nursing home care, for 1961, 1972, 1984, and 1989 are based on the Consumer Expenditure Survey (CEX). Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model.

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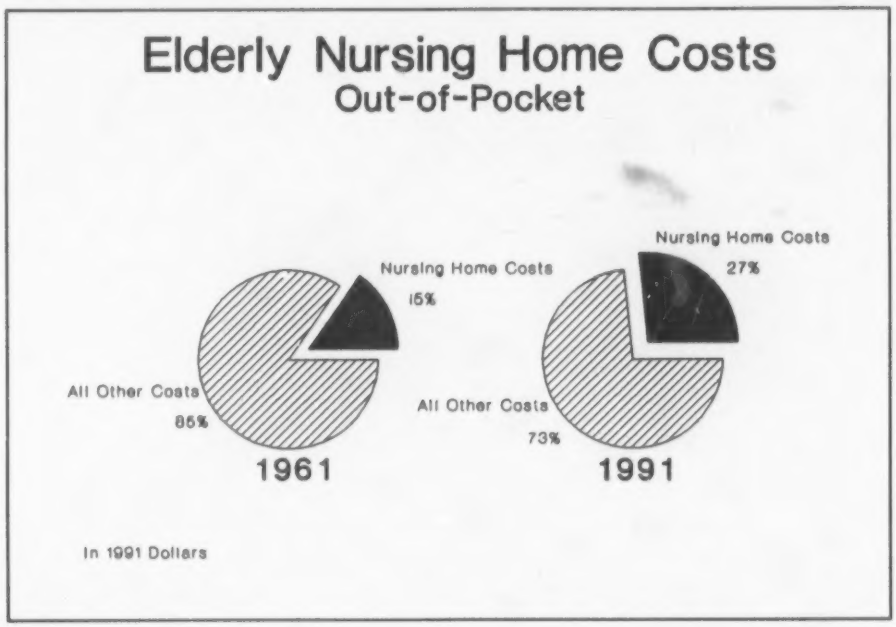
Nursing Home Costs

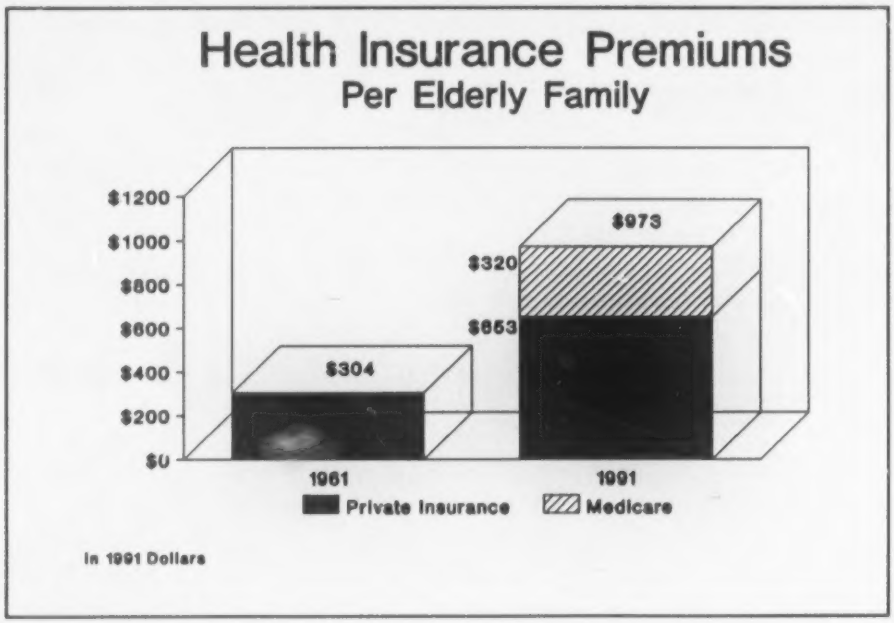
While overall out-of-pocket health care expenses for elderly families doubled in real dollars over the thirty years of the survey, costs did not increase uniformly. The single largest component of health care costs, and the fastest growing one, is nursing home expenses. These quadrupled since 1961 above general inflation (and increased more than 19-fold in nominal dollars). Uncovered by Medicare, these expenditures, which accounted for approximately one-sixth of all costs in 1961, now consume over one-third of elderly families' out-of-pocket expenses. As nursing home costs average over $30,000 annually and continue to rise, elderly families will continue to be financially devastated by these expenses.

The fact that nursing home costs virtually are uncovered by Medicare (Medicare pays 4.7 percent of nursing home costs nationwide) leaves the elderly vulnerable on two fronts. First, the elderly must pay these costs out-of-pocket and/or impoverish themselves and receive Medicaid assistance. Secondly, the amounts that the elderly must pay for nursing homes out-of-pocket largely are unregulated.



Premiums

Insurance premiums, both for private health insurance and Medicare, demonstrated the second largest expansion since 1961; growing more than three times in inflation-adjusted dollars (and almost 15 times in nominal dollars). The costs for private health insurance alone doubled above general inflation since 1961 (and increased close to ten times in nominal dollars), even though the nature of the market changed dramatically from being comprised solely of comprehensive policies to a market that is largely plans that supplement Medicare. Four out of five elderly families obtain Medigap policies in order to cover Medicare's extensive cost-sharing requirements. Other forms of health insurance, such as dread disease plans, account for a significantly smaller share of the market. Private health insurance now consumes the same proportion of out-of-pocket dollars, in 1991 dollars, as before Medicare began.



One of the reasons the elderly still have to spend so much on private insurance is that many Medigap policies have proven to be unnecessarily expensive. The low loss ratios for many Medigap policies are perhaps the best indicator of the inefficiencies of Medigap insurance. Loss ratios indicate the amount of money paid out as benefits compared to the amount taken in as premiums. A General Accounting Office study on Medigap policies found that approximately one-third of Medigap insurers have loss ratios less than 60%.[1] Such low loss ratios are indicators of excessive administrative costs, which tend to reflect high marketing costs and profits.

Also, close to one-quarter of seniors purchase two or more insurance policies in addition to Medigap.[2] Generally these are completely unnecessary purchases. Frequently, the elderly are encouraged to purchase duplicative policies by unscrupulous insurance agents who reap huge commissions from first year premiums. Confusion about what policies cover also leads the elderly to unknowingly purchase duplicate coverage. Recent federal legislation contained within the Omnibus Budget Reconciliation Act of 1990 is designed to protect seniors from some of the abuses associated with the sale of Medigap insurance, although it is just being implemented in 1992.[3]

Most Medigap policies do not cover services uncovered by Medicare (such as nursing home care, balance billing, prescription drugs, vision and dental care). Buying Medigap policies, therefore, does not eliminate a significant amount of out-of-pocket expenses for the elderly.

Premiums for Medicare Part B, a voluntary program covering physician costs that is financed by premiums from enrollees and general revenue, also have increased. Originally, the premium was to cover one-half of program costs. As health care costs began to escalate, Congress realized that elderly families could not afford half of the program costs. During much of the 1970s and 1980s, the Part B premium increased each year by the same amount as the Social Security cost-of-living adjustment (COLA). As of 1991, Congress set the premium to cover

one-quarter of program costs. Since the premiums are driven by program costs and therefore health inflation, the premium is certain to increase faster than the Social Security COLA.

Other Health Care Expenditures

Other out-of-pocket health care expenditures by the elderly including pharmaceuticals, dental services, eye care services, practitioners other than physicians (e.g. chiropractors), nursing services, therapeutic treatments, lab tests, X-rays, medical devices and supplies. These costs have increased by 41% in real dollars since 1961 (and increased over six-fold in nominal dollars). In large part this increase is driven by the costs of prescription drugs which, in 1991, accounted for over two-thirds of all such "other" medical expenditures.[4]

Physician And Hospital Costs

The Medicare program covers physician and hospital services more comprehensively than other medical services. Therefore, it is not a coincidence that these services, subject to the greatest federal control, have shown the smallest increases. Additionally, Medigap policies cover many of these costs. By contrast, areas of health spending where Medicare and Medigap coverage is minimal, such as nursing home costs, have shown the largest increases.

Physician services are one of the areas in which Medicare coverage is relatively comprehensive. The dollar amount spent by elderly families directly for physician services is, in real dollars, 29% above 1961 levels (and six times higher in nominal dollars). Yet, the portion of total out-of-pocket costs these services consume has decreased from 20% in 1961 to 12% in 1991. The decline in the percentage of out-of-pocket costs spent by elderly families directly for physician services is explained in two ways. First, physicians in increasing numbers have been accepting Medicare and its limited payment rates. Second, the elderly pay their share of physician costs largely through Medigap insurance. Increases in physician costs are reflected in the cost of Medigap premiums.

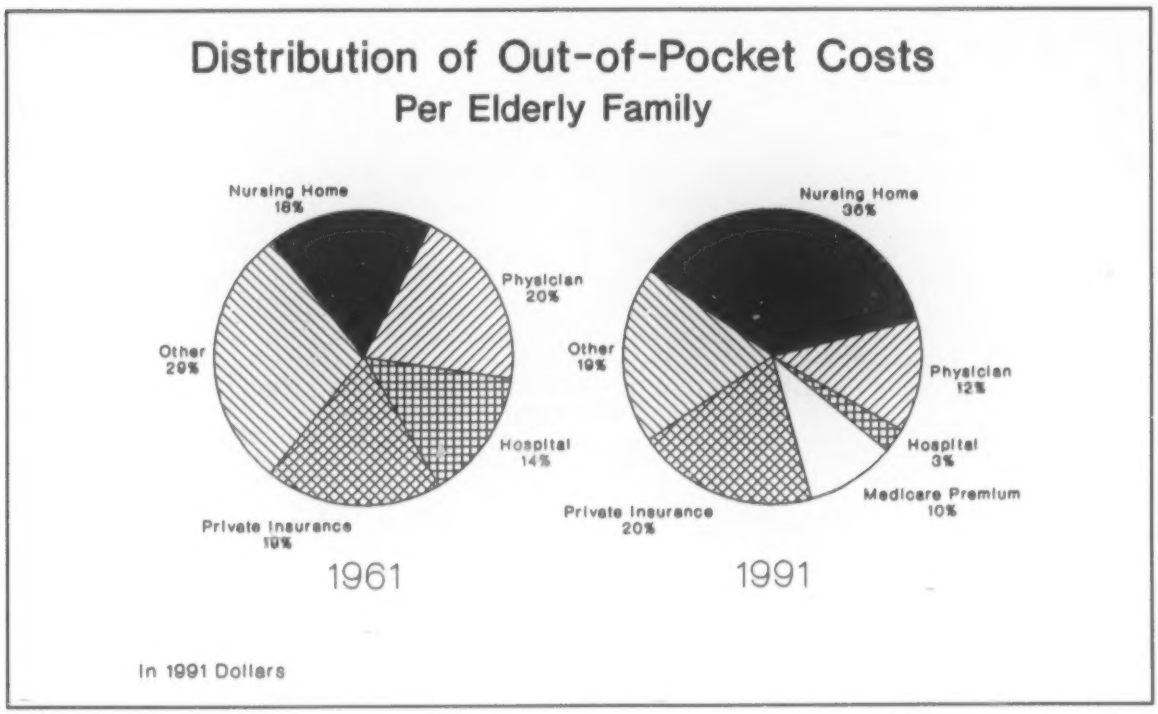
The elderly still pay directly for physician services in the form of balance billing. Balance billing is the term applied when physicians charge more than the Medicare allowed fee. According to the Health Care Financing Administration, balance billing cost elderly families $2.2 billion in 1989. Most Medigap policies do not cover balance billing. In 1990, Congress enacted legislation to stem this practice by placing caps on the amount a physician may charge a Medicare recipient. In 1992, that limit is 120% of Medicare's fee for a service.

As of 1991, Medicare enacted cost-controls designed to slow the rate of inflation in physician costs, which has significantly exceeded general inflation for many years. These controls include a volume performance standard to limit overall expenses and reform in physician payment rates to increase emphasis on primary care and limit payments for surgical services.

As Table 1A indicates, the costs of hospital services decreased significantly in real dollars since 1961. In real dollars these costs dropped by 60% since 1961. Once again, this decrease is attributable to Medicare's extensive coverage of the service and the fact that the elderly pay their share of hospital costs largely through Medigap insurance. Additionally, the effective cost-controls Medicare has placed on hospital costs, specifically the use of Diagnostic Related Groups (DRGs) reimbursement system beginning in 1984, have held down hospital increases in recent years. In 1991 alone, DRGs saved Medicare $30 billion in hospital costs.[5]

Distribution of Costs 1961 to 1991

As the pie charts below indicate, the components of elderly out-of-pocket costs have not increased uniformly since 1961. Hence, the make-up of elderly out-of-pocket expenses has changed significantly. The sharp reductions in out-of-pocket hospital and physician costs most likely are due to the considerable cost-controls placed on hospital services and the increased prevalence of Medigap insurance plans to cover Medicare's cost-sharing for hospital and physician costs. Additionally, the significant increases in nursing home costs are due both to high overall health care inflation and to Medicare's lack of coverage of nursing home care which, in the absence of meaningful cost controls, has proven financially devastating for many elderly families.



Health Expenses: A Growing Threat to Elderly Families' Income

While elderly families' health expenditures increased dramatically from 1961 to 1991, their income did not keep pace. As Table 2 indicates, elderly families spent more than one out of every six dollars in after-tax income on health care in 1991. This constitutes a 61% increase in the proportion of after-tax dollars devoted to health care costs in 1961. These amounts do not include any money spent on health care through general taxes and the Medicare payroll tax.

TABLE 2

ELDERLY FAMILY OUT-OF-POCKET HEALTH EXPENDITURES AS A PERCENT OF AFTER-TAX INCOME[a]

	1961	1972	1984	1989	1991[b]
Total	10.6%	10.6%	16.2%	16.6%	17.1%
Direct Out-of-Pocket	8.6	7.6	11.4	11.5	12.1
Insurance	2.0	3.0	4.8	5.1	5.0
Private Insurance	2.0	1.8	3.3	3.2	3.3
Medicare Premium	NA	1.2	1.5	1.9[c]	1.7

[a] Data for health expenditures other than nursing home care for 1961, 1972, 1984, and 1989 are based on the Consumer Expenditure Survey (CEX). Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model.

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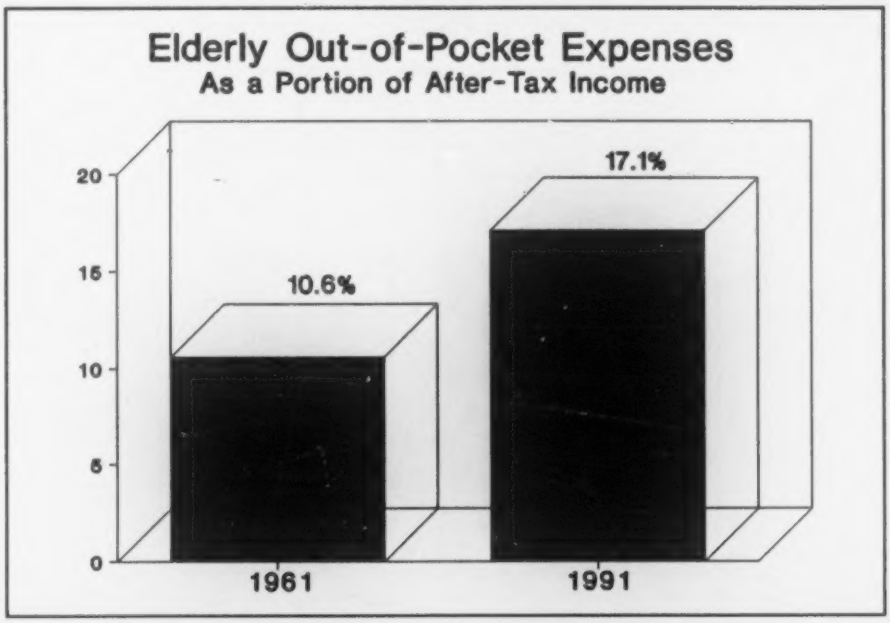
NOTE: Expenditures are for consumer units headed by someone age 65 or older. A consumer unit comprises either: 1) all members of a particular household who are related by blood, marriage, adoption, or other legal arrangements; 2) a person living alone or sharing a household with others or living as a roomer in a private home or lodging house or in permanent living quarters in a hotel or motel, but who is financially independent; or 3) two or more persons living together who pool their income to make joint expenditure decisions.



Elderly families with limited incomes spent much greater portions of their after-tax income for acute health care. Almost two out of every five (37.8%) of the elderly families in the lowest quintile are spending 20% or more of their after-tax income on health care, not including the costs of long term care. By contrast, as Table 3 indicates, only 4.3% of families with incomes in the highest quintile have such expenses. (Nursing home care could not be included in this calculation for technical reasons.) If nursing home care were included these numbers would escalate considerably since nursing home costs constitute over one-third of elderly families' out-of-pocket health expenses.

The percentage of elderly families with acute health expenditures in excess of 20% or more of after-tax income has grown for every quintile group except the highest from 1961 to 1989.

Conclusion

The data presented in this report clearly demonstrates that the elderly have been spending more money, and a larger part of their income, on health care than they did in 1961. This is particularly troubling in light of evidence that both health care inflation and the need for health care services will only increase in the coming decades. As the baby boom generation ages and the number of persons over 65 doubles between now and the year 2030 the demand for services will reach critical levels. Coupled with the spiraling growth of health care inflation this could prove catastrophic for the country. In order to provide a true safety net for elderly families, it is imperative, therefore, that health care costs be brought under control and that adequate services for such needs as long term care and prescription drugs.

TABLE 3

DISTRIBUTION OF ELDERLY FAMILIES BY
OUT-OF-POCKET HEALTH EXPENDITURES, EXCLUDING NURSING HOME COSTS, AS A PERCENT OF AFTER-TAX INCOME

	Percent of Families		Total	<5%		5-9.99%		10-14.99%		15-19.99%		20%+	
	1961	1989		1961	1989	1961	1989	1961	1989	1961	1989	1961	1989
All Elderly	100.0%	100.0%	100.0%	37.54	26.9%	27.2%	24.2%	13.6%	16.0%	7.7%	11.2%	14.1%	21.7%
Age of Reference													
65-74	68.8	59.1	100.0	39.4	32.0	28.0	23.9	13.6	15.2	7.6	10.3	11.4	18.6
75+	31.2	40.9	100.0%	33.2	19.6	25.2	24.5	13.5	17.1	8.0	12.5	20.1	26.3
Sex of Reference													
Male	65.0	56.3	100.0%	35.2	28.9	29.2	23.2	13.9	16.4	7.4	11.2	14.3	20.3
Female	35.0	43.7	100.0%	41.7	24.5	23.3	25.4	13.0	15.4	8.2	11.1	13.8	23.6
Marital Status													
Married	52.5	48.1	100.0%	31.7	25.2	30.9	23.5	15.1	17.0	8.2	12.0	14.1	22.3
Single	42.5	51.9	100.0%	43.7	28.7	23.0	24.7	11.9	15.0	7.2	10.4	14.2	21.2
Family Income*													
Lowest Quintile	20.0	20.0	100.0%	41.7	13.0	19.4	24.2	11.0	13.1	5.1	12.9	22.8	37.8
Second Quintile	20.0	20.0	100.0%	37.1	19.3	21.9	17.9	13.3	19.6	9.7	16.1	18.0	27.1
Third Quintile	20.0	20.0	100.0%	32.1	19.3	27.0	24.3	15.7	18.7	11.3	12.3	13.9	25.4
Fourth Quintile	20.0	20.0	100.0%	32.2	29.7	23.1	28.9	16.1	16.9	8.7	10.9	9.9	13.6
Highest Quintile	20.0	20.0	100.0%	44.6	55.2	34.4	25.8	11.6	11.6	3.6	3.1	5.8	4.3

- Income quintiles based on family before tax income. Quintile groups for 1961 were estimated to be less than $1,133 for the lowest quintile, $1,133 to $2,068 for the second quintile, $2,069 to $3,143 for the third quintile, $3,144 to $5,486 for the fourth quintile, and $5,487 or more for the highest quintile. Quintile groups for 1989 were estimated to be less than $7,183 for the lowest quintile, $7,183 to $11,060 for the second quintile, $11,061 to $16,517 for the third quintile, $16,518 to $27,144 for the fourth quintile, and $27,145 or more for the highest quintile.

NOTE: Estimates of out-of-pocket health expenditures do not include nursing home costs. Data are from the 1961 and 1989 Consumer Expenditure Surveys for consumer units headed by someone age 65 or older. A consumer unit comprises either: 1) all members of a particular household who are related by blood, marriage, adoption, or other legal arrangements; 2) a person living alone or sharing a household with others or living as a roomer in a private home or lodging house or in permanent living quarters in a hotel or motel, but who is financially independent; or 3) two or more persons living together who pool their income to make joint expenditure decisions.

Endnotes

1. *Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies*, United States General Accounting Office, October 1986, p. 25.

2. *Consumer Awareness of Medigap Insurance: Findings of A National Survey of Older Americans*, American Association of Retired Persons, 1989, Washington, DC, p.9.

3. Pub. L. 101-508

4. Lewin/ICF analysis of the Consumer Expenditure Survey.

5. *1990 Green Book*, Committee on Ways and Means, U.S. House of Representatives, p. 238.

Additional Tables

TOTAL OUT-OF-POCKET HEALTH EXPENDITURES BY THE ELDERLY[a]
(in millions of 1991 dollars)

	1961	1972	1984	1989	1991[b]
Total	$17,481	$27,176	$46,145	$60,645	$67,497
Direct Out-of-Pocket	14,142	19,501	32,458	41,564	47,626
Hospital	2,501	2,556	1,424	1,762	1,838
Physician	3,482	2,706	7,256	7,604	8,333
Nursing Home[c]	3,161	8,520	16,611	20,435	24,385
Other	4,998	5,719	7,167	11,763	13,070
Insurance	3,339	7,675	13,687	19,131	19,871
Private Insurance	3,339	4,529	9,465	11,996	13,336
Medicare Premium	NA	3,146	4,222	7,135[d]	6,535

[a] Data for health expenditures other than nursing home care for 1961, 1972, 1984, and 1989 are based on the Consumer Expenditure Survey (CEX). Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model.

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[c] The CEX is a survey of non-institutionalized consumer units and does not capture nursing home expenditures. Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model. Adjustments were made to account for the change in the number of families when including nursing home residents.

[d] Medicare premiums in 1989 are unusually high because the $31.90 monthly Part B premiums contained an additional $4.00 per month for Part B services to cover the costs of benefits added by the 1988 Medicare Catastrophic Coverage Act (MCCA). MCCA was repealed, therefore the 1991 monthly premium of $29.90 was lower than in 1989.

NOTE: Expenditures are for consumer units headed by someone age 65 or older. A consumer unit comprises either: 1) all members of a particular household who are related by blood, marriage, adoption, or other legal arrangements; 2) a person living alone or sharing a household with others or living as a roomer in a private home or lodging house or in permanent living quarters in a hotel or motel, but who is financially independent; or 3) two or more persons living together who pool their income to make joint expenditure decisions.

TOTAL OUT-OF-POCKET HEALTH EXPENDITURES BY THE ELDERLY[a]
(in millions of nominal dollars)

	1961	1972	1984	1989	1991[b]
Total	$3,816	$8,293	$35,002	$57,047	$67,497
Direct Out-of-Pocket	3,087	5,951	24,630	39,728	47,626
Hospital	546	780	1,080	1,595	1,838
Physician	760	826	5,504	6,884	8,333
Nursing Home[c]	690	2,600	12,600	20,600	24,385
Other	1,091	1,745	5,436	10,649	13,070
Insurance	729	2,342	10,382	17,319	19,871
Private Insurance	729	1,382	7,180	10,860	13,336
Medicare Premium	NA	960	3,202	6,459[d]	6,535

[a] Data for health expenditures other than nursing home care for 1961, 1972, 1984, and 1989 are based on the Consumer Expenditure Survey (CEX). Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model.

[b] Data for 1991 were estimated by Lewin/ICF.

[c] The CEX is a survey of non-institutionalized consumer units and does not capture nursing home expenditures. Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model. Adjustments were made to account for the change in the number of families when including nursing home residents.

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PERCENT DISTRIBUTION OF PER FAMILY OUT-OF-POCKET HEALTH EXPENDITURES BY ELDERLY FAMILIES[a]

	1961	1972	1984	1989	1991[b]
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Direct Out-of-Pocket	80.9	71.8	70.3	69.7	70.6
Hospital	14.3	9.4	3.1	2.8	2.7
Physician	19.9	10.0	15.7	12.1	12.4
Nursing Home[c]	18.1	31.4	36.0	36.1	36.1
Other	28.6	21.0	15.5	18.7	19.4
Insurance	19.1	28.2	29.7	30.3	29.4
Private Insurance	19.1	16.6	20.5	19.0	19.7
Medicare Premium	NA	11.6	9.2	11.3[d]	9.7

[a] Data for health expenditures other than nursing home care for 1961, 1972, 1984, and 1989 are based on the Consumer Expenditure Survey (CEX). Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model.

[b] Data for 1991 were estimated by Lewin/ICF.

[c] The CEX is a survey of non-institutionalized consumer units and does not capture nursing home expenditures. Nursing home care was added based on estimates from the Office of National Cost Estimates and the Brookings/ICF Long Term Care Financing Model. Adjustments were made to account for the change in the number of families when including nursing home residents.

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NOTE: Expenditures are for consumer units headed by someone age 65 or older. A consumer unit comprises either: 1) all members of a particular household who are related by blood marriage, adoption, or other legal arrangements; 2) a person living alone or sharing a household with others or living as a roomer in a private home or lodging house or in permanent living quarters in a hotel or motel, but who is financially independent; or 3) two or more persons living together who pool their income to make joint expenditure decisions.

Technical Appendix

The data presented in this report are based primarily on data from the Consumer Expenditure Survey (CEX). The CEX is an ongoing survey of the spending patterns and living costs of Americans conducted by the Bureau of the Census for the U.S. Bureau of Labor Statistics. The survey reports family expenditures for health care, including premium payments, any medical services (hospital, physician, eye and dental care, lab tests, X-rays, nursing, therapy services, and other medical care), prescription drugs, and medical supplies. Data from the CEX are available for 1960-61, 1972-73, and on an annual basis after 1980. We have used data for 1961, 1972, 1984 and 1989.

Expenditures for consumer units where the reference person was age 65 or older were used in this analysis.[1] A consumer unit comprises either: 1) all members of a particular household who are related by blood, marriage, adoption, or other legal arrangements; 2) a person living alone or sharing a household with others or living as a roomer in a private home or lodging house or in permanent living quarters in a hotel or motel, but who is financially independent; or 3) two or more persons living together who pool their income to make joint expenditure decisions. Financial independence is determined by three major expense categories: housing, food, and other living expenses. To be considered financially independent, at least two of the three major expenses have to be provided by the respondent. Because elderly units were identified by the age of the reference person, consumer unit expenditures for elderly persons that live in a household where the reference person was under the age of 65 are excluded.

In developing estimates for this study, we also used some non-CEX data including: 1) incorporating health expenditures for the institutionalized elderly, particularly nursing home care; 2) estimating 1991 out-of-pocket health expenditures for the elderly; and 3) estimating real expenditures. Our approach in each of these areas is discussed below.

▸ *Health Expenditures of the Institutionalized Elderly*

For non-institutionalized persons, per "family," total amounts, and out-of-pocket spending as a percent of income were adjusted to incorporate the spending of institutionalized persons,[2] because the CEX does not include adequate reporting for spending on nursing home care.[3] In order to incorporate spending for nursing home care into our estimates, we estimated the amount of out-of-pocket spending by the elderly for nursing home care using:

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1 The reference persons is the first member mentioned by the respondent when asked to "Start with the name of the person or one of the persons who owns or rents this home." It is with respect to this person that the relationship of other consumer unit members is determined.

2 Health spending for nursing home residents is the overwhelming majority of health spending for institutionalized persons among the elderly. A small proportion of institutionalized elderly persons are in prisons or institutions other than nursing homes.

3 A small amount of nursing home care expenditures for persons with a spouse in a nursing home or for persons who had a nursing home stay during the course of the survey year are reported in the CEX.

1) Office of National Costs Estimates (NCE) estimates of total nursing home spending; 2) assumptions concerning the amount of nursing home expenditures attributable to the elderly; and 3) assumptions about the percent of elderly nursing home care paid for out-of-pocket.

Figure 1 presents the steps associated with estimating the nursing home out-of-pocket spending for the elderly for 1961, 1972, 1984, and 1989. NCE estimates of expenditures for nursing home care were available for five year intervals from 1960 to 1985 and for 1989. To obtain estimates for the years for which we did not have CEX data, we interpolated between the available years using the annual rate of change over the period. These values are shown in Figure 1.

The next step involved estimating the percentage of total nursing home expenditures that were attributable to the elderly. We based our assumptions on estimates by Charles Fisher in "Differences by Age Groups in Health Care Spending," *Health Care Financing Review*, Spring 1980; Waldo and Lazenby estimates in "Demographic characteristics and health care use and expenditures by the aged in the United States: 1977-1984," *Health Care Financing Review*, Fall 1984; and the Brookings/ICF Long Term Care Financing Model.

In estimating nursing home expenditures of the elderly as a percent of total nursing home expenditures, Waldo and Lazenby data indicate that the elderly account for approximately 80 and 82 percent of total nursing home care expenditures in 1977 and 1984, respectively. NCE estimates for 1989 and Brookings/ICF model estimates for the elderly in 1989 indicate that elderly nursing home expenditures are about 80 percent of the total. Charles Fisher estimates that the elderly accounted for nearly 90 percent of nursing home expenditures prior to the Medicare and Medicaid programs. Based on these findings, we assumed that 90 percent of total nursing home expenditures were for the elderly in 1961 and 80 percent were for the elderly in 1972. We used direct estimates from Waldo and Lazenby for 1984 (82 percent) and Brooking/ICF model estimates for 1989 (80 percent).

To determine the percent of elderly nursing home expenditures that are paid out-of-pocket, we relied on the same sources of data as above. Charles Fisher indicates that in 1965 the elderly paid for 65 percent of nursing home care out-of-pocket. Both the Brookings/ICF model and the Waldo and Lazenby estimates indicate that more recently the elderly pay for approximately one-half to 54 percent of their nursing home care out-of-pocket. We used these estimates to calculate an estimate of elderly out-of-pocket spending for nursing home care in 1961, 1972, 1984, and 1989 (65, 49, 50, and 54 percent, respectively).

We compared the NCE estimates of elderly out-of-pocket nursing home spending in 1986 to estimates based on the Brookings/ICF Long Term Care Financing Model. Table 1 shows that the Office of National Costs Estimates (Waldo and Lazenby) estimates for out-of-pocket spending are within five percent of the Brookings/ICF model estimates.

These out-of-pocket spending data for nursing home care were incorporated into the total consumer out-of-pocket health spending estimates and the overall percent of income estimates. We did not incorporate nursing home expenditures into the distribution of families by out-of-pocket health spending as a percent of income levels because we would have had to assign nursing home expenditure levels to each consumer unit. This was not possible in the scope of this project.

FIGURE 1

METHODOLOGY FOR ESTIMATING ELDERLY OUT-OF-POCKET SPENDING FOR NURSING HOME CARE
(in billions of nominal dollars)

Year	Total Nursing Home Expenditures	Elderly Nursing Home Expenditures	Elderly Out-of-Pocket Nursing Home Expenditures
1960	$1.0		
1961	$1.1[a]	$1.0[b]	$0.7[c]
1965	$1.7		
1970	$1.9		
1972	$6.5[d]	$5.2[e]	$2.6[f]
1975	$9.9		
1977	$13.1[g]	$10.7[h]	$5.2[h]
1980	$20.0		
1984	$30.6[i]	$25.1[h]	$12.6[h]
1985	$34.1		
1989	$47.9	$38.1[j]	$20.6[j]

NOTE: Estimates are provided from NCE for five year intervals from 1960 and 1989.

[a] Estimate for 1961 based on 11.2% annual increase between 1960 and 1965.
[b] Assumed 90 percent of nursing home care was for elderly based on Charles Fisher estimates.
[c] Assumed elderly paid for 65 percent of care out-of-pocket based on Charles Fisher estimates.
[d] Estimate for 1972 based on 15.1% annual increase between 1970 and 1975.
[e] Assumed 80 percent of nursing home care was for elderly based on 1977 and 1984 Waldo and Lazenby estimates.
[f] Assumed elderly paid for 50 percent of care out-of-pocket based on 1977 and 1984 Waldo and Lazenby estimates.
[g] Estimate for 1977 based on 15.1% annual increase between 1975 and 1980.
[h] Direct estimates from Waldo and Lazenby.
[i] Estimate for 1984 based on 11.3% annual increase between 1980 and 1985.
[j] Estimates from the Brookings/ICF Long Term Care Financing Model.

TABLE 1

COMPARISON OF INSTITUTIONAL CARE ESTIMATES, 1986
(in millions of 1986 dollars)

	Out-of-Pocket Nursing Home Care
Brookings/ICF Model -- 1988	$15,100
Waldo and Lazenby -- 1984	$14,360

Out-of-pocket spending for health expenditures other than nursing home care were adjusted to incorporate the institutionalized population assuming that, on average, the institutionalized population had similar out-of-pocket expenditures as the non-institutionalized. It is unclear whether this assumption will bias the estimates upward or downward. Preliminary data from NMES indicate that total acute care health spending for the institutionalized elderly is approximately ten percent higher than acute acre spending for non-institutionalized elderly persons.[4] On the other hand, the majority of nursing home residents are on Medicaid, where out-of-pocket spending is generally not required for acute care services.

Average family income was also adjusted to reflect the average income of institutionalized persons based on results from the Brookings/ICF Long Term Care Financing Model.

▸ ***1991 Estimates***

Estimates for 1991 were developed based on assumed trends in per family out-of-pocket health care expenditures. Separate trends for hospital care, physician services, nursing home care, other direct medical expenses, and premium payments for private insurance and Medicare were applied to the per family amounts for 1989. These per family estimates were multiplied by the number of families in 1991 to calculate total out-of-pocket expenditures by elderly families in 1991. Finally, average family income for 1989 was adjusted to 1991 by the growth in the consumer price index.

[4] Conversation with Chris Murtaugh, AHCPR.

▸ *Real Out-of-Pocket Expenditure Estimates*

The estimates of nominal spending were adjusted for inflation based on changes in the consumer price index for urban consumers. Real dollar estimates are presented in 1991 dollars.